Physician-patient relationship: like marriage, without the romance

Physicians and philosophers have contributed to the field of medical ethics several different paradigms for the physician-patient relationship. I suggest another: marriage. Patients usually enter relationships as we enter marriage: we allow our high hopes to obscure the possibility of deep disappointment. The argument of the essay is to refocus on the contractual element of the physician-patient relationship.

Try as we might to overcome our emotions, they sometimes withstand even our best efforts. Particularly in medical care, fear and hope abound. Physicians and patients both would do well to consider how emotions can infiltrate our efforts to think clearly.

What kind of physician could keep her emotions under lock and key? Only one most of us would prefer to avoid. A reading of Aristotle, who links pity to fear, suggests that compassionate physicians may pity their patients for 2 reasons, 1 other-regarding (sadness about a patient) and the other self-regarding (fear that the physician could end up in the same condition). In *Rhetoric* (book 2, chapter 5), Aristotle states that, generally speaking, the same misfortunes that cause us to pity others elicit real fear when they happen to us.[1(p1390)] He does not exactly say that fear and pity differ only in whether the misfortune happens to us or to someone else; his point is, rather, to balance these psychological reactions on a fulcrum of emotional closeness. These emotions arise in the context of caring for others: Aristotle believes that we can only fear for other people or pity them if they matter to us in some important sense (*Rhetoric:* book 2, chapter 8).[1(pp1397-1398)]

Sick people want help. They naturally invest hope in the physicians they find. I want to examine the idea that patients as a group dislike thinking unpleasant thoughts. (No doubt physicians do, too, although probably less so in the health care setting.) A study demonstrated that most patients who have not discussed preferences for end-of-life care do not want to do so.[2] Most patients and physicians have not discussed end-of-life decisions, and most patients have not completed advance directives. A culture heavily invested in "the power of positive thinking" produces patients who may resist thinking about the possibility that their physicians will disappoint them. Do caring physicians reinforce their patients' natural aversion to bad thoughts?

So general a question cannot be answered definitively. However, something approximating an answer emerges from comparing the patient-physician relationship with marriage. Various scholars have pointed out the peculiarity of our relatively recent and predominantly western notion that marriage should be based on love.[3-5] Even after the Roman Catholic Church came to characterize marriage as

John Portmann
Executive Assistant to the Provost
University of Virginia
Fontaine Research Park
PO Box 400308
Charlottesville, VA
22904-4308

Correspondence to:
Dr Portmann
portmann@virginia.edu

Competing interests: None declared

Modified from an article published in *J Med Ethics* 2000;26:194-197

a sacrament—that is, a means through which to encounter God—many families regarded marriage as a largely economic arrangement. A dowry could determine a woman's fate. The romantic or erotic aspect aside, marriage more closely resembles patient-physician relationships than friendship, for friendship does not involve a legal agreement. The stakes in both marriage and patient-physician relationships loom higher than in friendship.

Patients and physicians alike hope for a happy ending—and appropriately so. For this reason, patients and physicians have something important to learn from prospective spouses.

WHEN PATIENTS AND PHYSICIANS MEET

Virtually all patients hope, and some even hope against hope. Few surrender immediately to their illnesses. Biotechnology has given patients more reason to hope, even to hope against hope. Broad-based astonishment at the extraordinary progress of medicine in the past few decades is a cultural phenomenon of which physicians must be aware if they are to understand the expectations of patients.

Physicians naturally hope for the best for their patients as well. That physicians should establish better "connections" with their patients has become a regular theme in the literature of biomedical ethics.[6] Some writers in this field do a better job than others of bringing out the possible risks of establishing closer relationships with patients. One physician claimed in *The Journal of the American Medical Association*: "for me, fulfillment comes from the sudden intimacies with total strangers—those moments when the human barrier cracks open to reveal what is most secret and inarticulate."[7] Another physician has strongly urged empathy in clinical encounters and has argued that passion is a part of that empathy.[8]

Some patients expect their physicians to fill the role of a powerful paternal or maternal figure.[9] By the same token, some physicians are comfortable only in relationships in which they are taking care of and controlling others.[10] Even aside from relatively marginal cases, emotions can pervade physician-patient relationships.

No matter what else it aims to be, the patient-physician relationship is a contract involving the exchange of money and services. Timothy Quill has specified that 4 assumptions underlie the physician-patient contract: both the physician and the patient have unique responsibilities; the physician-patient relationship is consensual, not obligatory; both the physician and the patient must be willing to negotiate; and physician and patient each must gain something in their encounters.[11] Nothing in this list contradicts a contractual description of marriage, which similarly stands on an exchange of money and services.

Many experts in the field of biomedical ethics agree that the patient-physician relationship is more a covenant than a contract. This is not to say, however, that consensus exists on this point. The western institution of marriage represents both a covenant and a contract. Broadly speaking, western culture leads people to view matrimony as a covenant and, in so doing, encourages them to ignore the contractual nature of the institution. Married persons who face divorce for the first time frequently come to view the institution very differently—that is, as a contract. Patients disappointed by their medical care may well take a similar mental turn. Many medical malpractice suits begin in this way.

WHEN PROSPECTIVE SPOUSES MEET

Aristotle marries fear and pity in a way that requires emotional proximity. Although he does not mean or even mention marriage, he introduces the notion of affective ties in a way that makes marriage relevant to a discussion of what happens when physicians and patients meet. Just as prospective spouses focus on positive outcomes, so, too, do prospective physicians and patients work from a natural aversion to bad thoughts. What can physicians and patients learn from the legal institution of marriage?

The American legal scholar Lynn Baker has usefully illuminated the contractual nature of marriage. She points out that although little about the present legal procedures for getting married would cause one to think that a contract is being entered into, the law has long explicitly characterized marriage as a legal "contract" among husband, wife, and the state.[12] When people marry, they agree to be bound by the various laws that constitute the

implied terms of the marriage contract. At the time people apply for a marriage license, the state necessarily possesses the most complete possible knowledge of the legal terms of the marriage contract; however, it generally does not take any action to disclose even a portion of that information to the parties requesting to be married. Nor does the state require spouses-to-be to demonstrate that they have grasped the terms of the contract into which they are about to enter. I take Baker's point to apply to European marriages as well as to American ones, although I acknowledge differences between the 2 (for example, monetary settlements for both divorce and malpractice tend to be higher in the United States).

Baker's writings raise a question regarding informed consent for people engaged to be married that extends naturally to people in search of a physician: why is it that the law does not compel patients to learn before choosing a physician what the legal character and consequences of their acts are and, further, help them to predict with reasonable certainty the outcome of any subsequent adjudication regarding possible adverse outcomes? Baker has elsewhere argued that people simply do not wish to consider the possible adverse outcomes of a marriage contract. She has written,[13]

> [W]e . . . seem to believe that knowledge of the law, even taken alone, is not always and unambiguously better than ignorance. For sometimes that knowledge comes at the cost of dimming, if not entirely dispelling, our most precious ideals and cherished hopes. And that price is one we cannot afford to pay.

Prompting patients and potential patients to view their relationships with physicians as a covenant may be grounded in, and appeal to, their hope for recovery and may result in a susceptibility to overlook the contractual nature of their interaction with a physician.

In a separate work, Baker surveyed marriage license applicants and law students about their knowledge of divorce statutes and of the demographics of divorce and their expectations for their own marriage.[14] Both groups had largely incorrect perceptions of the legal terms of the marriage contract as embodied in divorce statutes, but both groups had relatively accurate, if sometimes optimistic, perceptions of both the likelihood and the effects of divorce in the population at large. These same persons expressed thoroughly idealistic expectations about both the longevity of their own marriages and the consequences of divorce. Increasing people's knowledge of divorce statutes through a course on family law did not diminish this unrealistic optimism. Baker's findings strongly suggest that the sense of surprise that frequently attends divorce may be a result of systematic cognitive biases rather than a lack of information about divorce.

Respondents' predictions for the permanence of their own marriages and the consequences should they be divorced were much more optimistic than their perceptions of the likelihood and effects of divorce on others. For example, although their median estimate that 50% of American couples who marry will divorce was accurate, the median response of the marriage license applicants when assessing the likelihood that they personally would divorce was 0%.

AVERSION TO BAD THOUGHTS

After reading Baker's work, we more readily understand why prenuptial contracts are so rarely used and their lack so often regretted. Baker's work may have something to say to clinicians who ponder why so few people have drawn up advance directives about end-of-life health care. The kind of thinking about patient-physician relationships outlined by the articles cited here discourages questions about malpractice or unhappy endings. Just as persons tend strongly to dislike considering possible adverse outcomes of matrimony, they may strongly dislike thoughts of adverse outcomes with physicians.

Perhaps the easiest way to avoid thinking of an unappealing possibility is to ignore the contractual nature of the relationship and to view that relationship as a loving covenant instead. For physicians, the importance of negotiating a proclivity to pity or to feel compassion for their patients would seem to consist at least in part in recognizing their own fears. The advantages to thinking of physician-patient relationships in largely business terms extend to patients as well: a frank discussion of bad news grows out of a genuine concern for patients. For a physician to crouch with a patient behind illusions of safety or veils of undaunted optimism would be cowardly.

What I advocate, then, is a renewed focus on the contractual element of physician-patient relationships. There are, of course, objections to the view that a physician-patient relationship is more a contract than a covenant. Those who defend the covenant model at times criticize contracts as too individualistic and at times as minimalistic (specifying only the moral minimum of the relationship). At other times, the contract model is rejected as externalistic (emphasizing external actions rather than the spirit of the relationship and the character of the agents) and legalistic (focused on legal enforcement). Those who prefer to discuss the patient-physician relationship in the language of loyalty and faith rely on virtues rather than on principles and rules. The eminent bioethicist Robert Veatch and other defenders of a contract model reply that a covenant is only a special form of contract that emphasizes moral relationships such as fidelity; they also maintain that medical ethics is best understood in terms of a broader nexus of contracts between society, the professions, and patients. Tom Beauchamp and Jim Childress

have brought this debate to life in various editions of their influential *Principles of Biomedical Ethics.*[15]

Perhaps the strongest justification for framing physician-patient relationships in terms of a covenant is that covenants seem to come down to one-sided promises between someone with power, wealth, or both and someone less powerful or wealthy. In the past 3 decades, though, legal recourse has greatly increased the power of a patient to fight a physician. The very idea of a malpractice suit impoverishes the covenant model of physician-patient relationships. That said, I have argued that patients tend to resist thinking of malpractice suits, more or less in the same way that betrothed persons resist thinking about divorce.

Although my sympathy ultimately lies with Veatch, I think that reducing relationships between physicians and patients to any single metaphor (for example, confessor, parent, friend, spouse, or expert consultant) or model will prove inadequate. The complexity of health care and the moral principles and rules that should govern such relationships compel us to think in broader terms than just contracts and covenants. We need not take a position on the debate over whether the patient-physician relationship is a covenant or a contract to conclude that the contractual dimension of the relationship can usefully offset the marriage of pity and fear Aristotle articulates.

THE ETHICS OF HOPING

The problem of many patients includes an important psychological component: illness threatens their connection to the vividness and vibrancy of the world. New medical technologies and the faith patients have in them make it easier than ever to seek to avoid the natural unpleasantness surrounding illness. Hope seems ever more rational. Physicians ought to be aware of the possible pitfalls inherent in the psychological aspects of physician-patient relationships. And those writing in the fields of biomedical ethics and medical humanities ought not to disguise or sugarcoat those pitfalls. Managing the expectations of patients demands sensitivity to their occasional delusions of control and the fragility of hope. Managing the expectations of patients requires vigilance over what Aristotle identifies as a natural tendency to indulge emotionally those we care about.

References

1 McKeon R. *The Basic Works of Aristotle: Rhetoric.* New York: Random House; 1941.
2 Hofmann JC, Wenger NS, Davis RB, et al. Patient preferences for communication with physicians about end-of-life decisions. *Ann Intern Med* 1997;127:1-12.
3 Boswell J. *Christianity, Social Tolerance, and Homosexuality.* Chicago: University of Chicago Press; 1980.
4 Singer I. *The Nature of Love.* Chicago: University of Chicago Press; 1984.
5 Hirshman LR, Larson JE. *Hard Bargains: the Politics of Sex.* Oxford, UK: Oxford University Press, 1998.
6 Matthews DA, Suchman AL, Branch WT. Making "connexions": enhancing the therapeutic potential of patient-clinician relationships. *Ann Intern Med* 1993;118:973-977.
7 Radetsky M. Sudden intimacies [editorial]. *JAMA* 1985;254:1361.
8 Spiro H. What is empathy and can it be taught? *Ann Intern Med* 1992;116: 843-846.
9 Engel GL. "Psychogenic" pain in the pain-prone patient. *Am J Med* 1959;26:899-918.
10 Alder G. Helplessness of the helpers. *Br J Med Psychol* 1972;45:315-316.
11 Quill TE. Partnerships in patient care: a contractual approach. *Ann Intern Med* 1983;98:228-234.
12 Baker L."I think I do": another perspective on consent and the law. *Law Med Health Care* 1988;16:257-260.
13 Baker L. Promulgating the marriage contract. *Univ Mich J Law Reform* 1990;23:217-264.
14 Baker L. When every relationship is above average: perceptions and expectations of divorce at the time of marriage. *Law Hum Behav* 1993;17:439-450.
15 Beauchamp T, Childress J. *Principles of Biomedical Ethics.* 3rd ed. Oxford, UK: Oxford University Press; 1989.

capsule

Multivitamins should be taken early in pregnancy Research has shown that congenital heart disease is less common in infants born to mothers who took multivitamins early in pregnancy (*Am J Epidemiol* 2000;151:878-884). No risk reduction was evident when the use of vitamins began after the first month of pregnancy. The message is that periconceptional behavior is crucial to the health of the embryo.

capsule

Dying people still want to care for others Many people are not afraid of death; they are afraid of a bad death. A good death means freedom from pain and breathlessness, and clear communication with caregivers. It also means being able to contribute to the welfare of others, a new theme that emerged from qualitative research reported in *Annals of Internal Medicine* (2000;132:825-32). People who are dying are not helpless; like everyone else, they do not like to feel useless.